Raising standards in emergency relief: how useful are Sphere minimum standards for humanitarian assistance?

André Griekspoor, Steve Collins

Médecins Sans Frontières, Amsterdam, Netherlands
André Griekspoor *head of the monitoring and evaluation unit*

Valid International, Oleuffynon, Llanidloes, Powys SY18 6PJ
Steve Collins *director*

Correspondence to: A Griekspoor, 148 Impasse du Saugy, 01210 Ornex, France
griekspoora@who.ch

BMJ 2001;323:740–2

International humanitarian agencies have recently developed a set of standards governing the implementation of relief programmes.[1] The Sphere standards were developed in response to concerns about the quality and impact of humanitarian assistance and are analogous to those set for healthcare services in developed countries.[2 3] Although the standards have been generally welcomed, concerns have been raised about their use.[4 5] One worry is that the main measures apply only to ideal situations in relief camps and that standardisation will prevent relief workers from adapting in more complex situations. Another fear is that politicians could use the standards to obscure their responsibilities to tackle the underlying causes of emergencies. Finally, the indicators could foster unrealistic expectations while ignoring constraints. This could lead to unjustified adverse publicity, liability, and reprisals.[6 7] In this article we describe the standards and assess their usefulness by considering the application of nutritional standards in the 1998 famine in Sudan.

Summary points

- In January 2000, the Sphere project published the first handbook describing minimum standards and related key indicators applicable to emergency relief programmes
- The handbook aims to stimulate learning and accountability by measuring process and outcome
- The standards and key indicators are minimum values for beneficiaries but cannot always be used as planning objectives by humanitarian agencies
- Assessment of performance of single agencies must take into account the general context of the emergency, particularly resource availability, access, and interventions by others
- Use of technical standards must be accompanied by an obligation on states to respond to humanitarian emergencies and guarantee the rights of populations

Development of standards

The Sphere project is a consortium of the international humanitarian community set up to establish what is technically and normally possible for relief operations.[8] More than 700 people from 228 relief organisations in 60 countries considered ideas on good practice over three years. The results were published in a handbook in January 2000.[1] The Sphere handbook contains a humanitarian charter and minimum standards, accompanied by key indicators for five sectors of disaster response: water supply and sanitation, nutrition, food aid, shelter and site management, and health services. The charter recognises the basic right to assistance of people affected by disasters, enshrined in international law. It highlights the legal responsibility of states to guarantee these rights. The standards are formulated as principles or objectives, and the box gives examples of standards on nutrition. The key indicators are quantified indices to measure fulfilment of the standards.

Famine in Sudan, 1998

The 1998 famine in southern Sudan was another catastrophic episode in the continuing civil war.[9] In January 1998, during a period of severe drought, a resurgence of fighting around the government held towns of Wau and Gogrial displaced about 130 000 people. This destroyed any remaining coping mechanisms and precipitated intense famine. Deliberate manipulation by the warring parties aggravated the desperate situation. By imposing a succession of flight bans and allowing access to only a few sites, the Sudanese government concentrated relief efforts in a few villages. Insecurity on both sides of the frontline restricted movement of aid workers and forced teams to evacuate periodically. Displaced people who had gathered together had no access to clean water, sanitation, or health facilities and, despite relief efforts, had grossly insufficient quantities of food. Malnutrition combined with epidemics of diarrhoea killed tens of thousands of people.

To have an impact in such a resource depleted situation, relief programmes must ensure that most of the population has access to minimum life sustaining requirements: sufficient general food rations, adequate water, sanitation, and basic health care. Unless these basic requirements are met, additional selective feeding programmes, aimed at providing special food for those with malnutrition, cannot produce a lasting decrease in mortality.

Examples of Sphere standards for emergency nutrition interventions

Standard 1: assessment
Before any decisions are made about a programme, aid workers must demonstrate understanding of the basic nutritional situation and conditions that may create a risk of malnutrition

Standard 2: response
If nutritional intervention is required, the problems must be clearly described and the strategy for response documented

Standard 3: monitoring and evaluation
The performance and effectiveness of the nutrition programme and changes in the context must be monitored and evaluated

Standard 4
The public health risks associated with moderate malnutrition are reduced

Standard 5
Mortality, morbidity, and suffering associated with severe malnutrition are reduced

Relief programmes for areas affected by drought will usually include feeding centres. Supplementary feeding centres provide moderately malnourished people with a weekly ration of enriched blended cereal flour to take home, whereas therapeutic feeding centres provide severely malnourished people with 24 hour inpatient care. Inpatients receive therapeutic milks tailored to their individual metabolic needs, as well as intensive medical and nursing care and systematic broad spectrum antibiotic and antihelminthic drugs.[10]

Most of the humanitarian relief for the 1998 famine was provided by Operation Lifeline Sudan, an umbrella group comprising the United Nations and international and national non-governmental organisations. As in many major emergencies, the World Food Programme provided general rations. Médecins Sans Frontières Holland set up two therapeutic feeding centres in Wau, which had a population of 150 000, and supported the town's hospital. It also ran therapeutic and supplementary feeding centres and supported primary healthcare centres in Panthou, Ajak, and Tieraliet, three villages of 5000-10 000 people controlled by the Sudan People's Liberation Army (figure).

Were Sphere standards met?

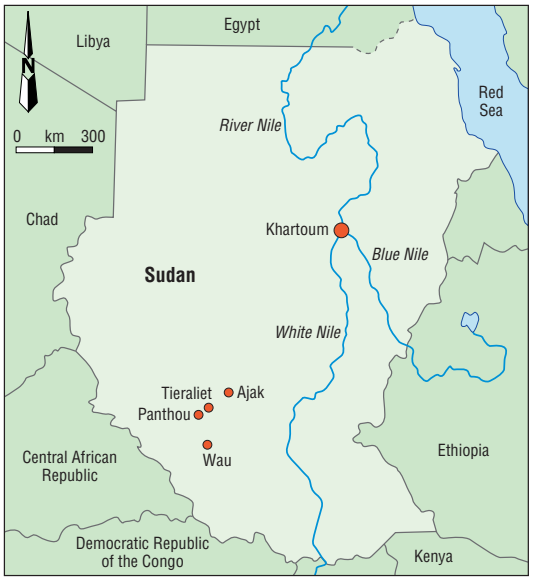
Sphere recognises that factors outside the control of humanitarian agencies affect their ability to meet minimum standards of service provision. Four prerequisites need to be met: everyone involved in humanitarian assistance should share a common goal; there should be access to the afflicted population; sufficient funds should be available; and everyone should be committed to meet minimum standards.

In Sudan during 1998, none of these underlying assumptions were met. The humanitarian crisis and the response were highly orchestrated by the Sudanese governments and the Sudan People's Liberation Army. Access was severely restricted. The flight restrictions flouted international humanitarian law that obliges states to agree to the provision of humanitarian assistance.[11 12] Large amounts of relief grain were diverted to the military so that the general ration remained well below requirements.[13] Adequate donor funding was available only after June, when pictures of starving children appeared on Western television. In our experience, these findings are not abnormal in large scale complex emergencies.

The relief intervention aimed to provide the greatest amount of good for the greatest amount of people. However, the needs were overwhelming and the resources were grossly inadequate. The utilitarian principle conflicted with the desire to provide minimum levels of individual care described by the Sphere key indicators. Médecins Sans Frontières did not have the capacity to tackle the underlying problem of inadequate food distribution. Therefore, in consultation with Operation Lifeline Sudan, it implemented selective feeding programmes while advocating improvements in the general ration. Although it realised that this intervention would have limited impact if the wider problems were not tackled, it believed that solidarity and advocacy were important reasons justifying an intervention. Médecins Sans Frontières therefore established a field presence knowing that it was unrealistic to meet all Sphere's process and outcome key indicators (tables 1 and 2).

Médecins Sans Frontières' solution to this problem was to make admission criteria more stringent but maintain a high level of care. For example, the therapeutic feeding centres admitted only children who were less than 60% of their weight for height instead of the usual level of 70%. Because the centres admitted only the most severely malnourished children, recovery rates inevitably fell below the indicated norm of 75% after two months. The coverage of the feeding programmes in all locations was low, varying from 10% to 33%.

An evaluation of the programme concluded that the intervention could have had greater effect if Médecins Sans Frontières had deviated further from the Sphere standards.[14] It suggested that triage methods, prioritising less intensive treatment for those having better survival chances, would have been more



Location of humanitarian relief operation by Médecins Sans Frontières, Holland

Table 1 Key indicators for supplementary feeding programmes

	Panthou	Tieraliet	Ajak
No increase in levels of severe malnutrition or no increase in number registered in therapeutic feeding centres	No	Yes	Yes
Surveillance systems established to monitor nutritional trends	Yes	Yes	Yes
Programme objectives reflect understanding of causes and identified target groups	Yes	Yes	Yes
Staff trained in principles of feeding infants and young children	Yes	Yes	Yes
Clearly defined and agreed criteria for closing the programme	No	No	No

Table 2 Key indicators for therapeutic feeding centres

	Panthou	Wau
Mortality rate <10% in 1-2 months	No*	Yes*
Recovery rate >75% in 1-2 months	No*	No*
Default rate <15% in 1-2 months	No*	No*
Mean daily weight gain >8 g/kg per person	No*	No*
Nutritional and medical care based on clinically proved therapeutic care protocols	Yes	Yes
Staff patient ratio ⩾1:10	Yes	Yes
Discharge criteria include non-anthropometric (clinical) indices	Yes	Yes
Staff able to feed and care for patients	Yes	Yes

*Admission criterion was <60% weight/height, but these indicators were developed for <70%weight/height.

cost effective.[15] Large scale feeding centres with reduced quality of treatment for individuals would have freed up capacity to increase the coverage of the programme. For example, not providing intravenous rehydration would have avoided staff wasting time trying to find parenteral access for patients with little hope of survival. A triage strategy could have achieved lower overall mortality by accepting higher death rates among the most severely malnourished.

Such decisions are extremely difficult and require considerable experience and professional acumen. The Sphere handbook does not help in these dilemmas. As Sphere does not include an indicator for programme coverage, small intensive programmes with low death rates but low coverage and therefore low impact seem more effective than large less intensive programmes with higher death rates but higher coverage and impact. This omission should be corrected in subsequent editions of the standards.

Conclusions

The Sphere handbook defines minimum service standards from the perspective of beneficiaries. However, the assumptions behind these standards, such as unhindered access and adequate resources, are rarely met during large scale humanitarian emergencies. Such constraints restrict the effectiveness of all humanitarian interventions. This case study shows that trying to adhere to preset indicators when needs are overwhelming compared with the available capacity for response could promote inappropriate planning. The Sphere nutritional key indicators emphasise individual cure rates rather than overall impact at the population level. Triage is needed to obtain an optimal balance between quality of individual care and coverage of the programme. Relief workers must be prepared to define innovative approaches aiming at the highest effect possible with the given resources.

The need for triage of entire populations is a sad comment on the state of the "global village." It reflects a failure of politicians and governments to meet their humanitarian responsibilities. Campaigns to point out these obligations under international humanitarian law, as emphasised in the humanitarian charter, must be reinforced. The Sphere handbook must be used as a whole and not just as a technical reference. This minimises the scope for politicians to divert attention away from underlying political failures by scapegoating humanitarian agencies for not meeting technical standards.

The success and immediate uptake of Sphere by humanitarian agencies, donors, and the media has its dangers. It is vital that agencies attempt to uphold standards of interventions and that they are accountable to donors, the media, and to those afflicted by disaster. Nevertheless, in the absence of other tools, politicians and the media might be tempted to judge agencies solely on adherence to Sphere's indicators. A simple comparison of figures could lead to naive assessments. The standards should be seen as references when judging the performance of single agencies. The wider humanitarian community and media need to understand that achievements must be analysed within their context, taking into account available resources, access, and interventions by others.

Competing interests: None declared.

1 *The sphere project: humanitarian charter and minimum standards in disaster response*. 1st ed. Oxford: Oxfam, 2000.
2 Harrel-Bond B. *Imposing aid: emergency assistance to refugees*. Oxford: Oxford University Press, 1986.
3 Relief and Rehabilitation Network. *The joint evaluation of emergency assistance to Rwanda: study III. Principal findings and recommendation*. London, Overseas Development Institute, 1996. (RRN paper 16.)
4 Gostelow L. The Sphere project: the implications of making humanitarian principles and codes work. *Disasters* 1999;23:316-25.
5 Open letter, written by representatives of Action Contre le Faim, Institute de l'Humanitaire, Médecins Du Monde, Médecins Sans Frontières France and Groupe Urgence Réhabilitation et Développement. Paris, September 10, 1998. www.urd.org (debates, accessed 15 August 2001).
6 The Sphere project conference report, London, 3 December, 1998. www.sphereproject.org (accessed 14 Feb 2000.)
7 Buzard N. Benchmarks, sticks or carrots? Differing perceptions of the role of standards. *Relief and Rehabilitation Network Newsletter* 1998;12:13-4.
8 The Sphere project. www.sphereproject.org (accessed 14 Feb 2000).
9 Keene D. Making famine in Sudan. *Field Exchange* 1999;6 (Feb):6-7.
10 Médecins Sans Frontières. *Nutrition guidelines*. 1st ed. Paris: MSF, 1995.
11 Universal Declaration of Human Rights 1948. Articles 3 and 5 www.un.org/Overview/rights.html (accessed 10 June 2001)
12 Protocol additional to the Geneva conventions of 12 August 1949, and relating to the protection of victims of international armed conflicts (protocol 1). Articles 69 to 71. http://www.unhchr.ch/html/menu3/b/93.htm (accessed 10 June 2001).
13 Danida, Ministry of Foreign Affairs. *Report on the evaluation of Danish humanitarian assistance to Sudan, 1992-98*. Vol 7. *Sudan*. Copenhagen: Danida, 1999:42.
14 Collins S. MSF in catastrophe: *Evaluation report of the MSF Holland programmes in Bahr El Gazal and western upper Nile in 1998*. Amsterdam: Monitoring and Evaluation Unit, MSF Holland, 1999. (Evaluation series No 9.)
15 Briggs SM, Leong M. Classic concepts in disaster medical response. In: Leaning D, Briggs SM, Chen LC, eds. *Humanitarian crises*. Cambridge, MA: Harvard University Press, 1999:69-80.

(Accepted 18 June 2001)

Endpiece

The final quip

You know that I'm at death's door. But the trouble is that I'm afraid to knock.

Said by Somerset Maugham (1874-1965) to his nephew, Robin Maugham, in 1965. Maugham qualified at St Thomas's Hospital Medical School but never practised.

Submitted by Fred Charatan, retired geriatric physician, Florida